COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

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AAA TUESDAY E-MAILING
April 13, 2004

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Virginia department for the Aging

COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: AAA Directors

FROM: Bill Peterson

DATE: April 13, 2004

SUBJECT: **Older Virginians Month Proclamation**

Attached is a .pdf file of the 2004 Older Virginians Month proclamation that Governor Warner recently signed.

Attachment

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CERTIFICATE of RECOGNITION

By virtue of the authority vested by the Constitution in the Governor of the Commonwealth of Virginia, there is hereby officially recognized:

OLDER VIRGINIANS MONTH

WHEREAS, Virginians of all ages contribute greatly to the history, culture and welfare of our great Commonwealth; and

WHEREAS, more than one million Virginians are at least sixty years old, and the population of Older Virginians will grow to more than two million, or one quarter of Virginia's population, in the next twenty-five years; and

WHEREAS, Older Virginians are taking better care of themselves by remaining physically active, eating healthier and getting regular health screenings, and they are living longer, healthier and more productive lives than ever before; and

WHEREAS, Older Virginians are preparing for a healthy future by learning about housing and long-term care options, becoming more financially literate, and seeking opportunities for community involvement, social engagement and leisure; and

WHEREAS, Older Virginians are active members of their families and communities who serve as volunteers, employees and mentors, and they are influential role models who instill an appreciation for American values in Virginia's youth; and

WHEREAS, it is important for Virginians to recognize, appreciate and learn from the knowledge and experiences of our Commonwealth's senior population, and it is fitting to acknowledge the many accomplishments and contributions of Older Virginians and to look forward to their continued involvement in our lives and in our communities;

NOW, THEREFORE, I, Mark R. Warner, do hereby recognize May 2004 as **OLDER VIRGINIANS MONTH** in the **COMMONWEALTH OF VIRGINIA**, and I call this observance to the attention of all our citizens.

Mark R Warner
Governor

Anita A. Rimler
Secretary of the Commonwealth

COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: AAA Directors

FROM: Bill Peterson

DATE: April 13, 2004

SUBJECT: **Medicaid Dual Eligibles**

Dual enrollees in Medicare and Medicaid are among the poorest and sickest health care users in the nation. Although dual eligibility is complex and confusing for those individuals (and their caseworkers) who qualify, dual enrollment offers greater coverage for this very needy group of Virginians.

I have attached two items that may help your staff better understand the benefits of dual eligibility. The first is a publication by the Center for Medicare Education titled *Dual Eligibles* that offers tips for how you can help clients maximize their benefits. The second is a handout prepared by DMAS titled *The Medically Indigent* which provides a very brief guide to eligibility criteria for dual eligibles as well as qualified disabled and working individuals and includes selected incomes and resource levels.

Attachments

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CENTER FOR MEDICARE EDUCATION

ISSUE BRIEF
VOL. 5, NO. 2, 2004

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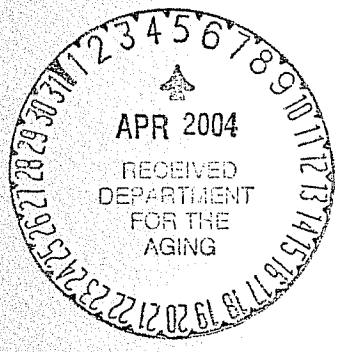

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A project of the American Association of Homes and Services for the Aging with funding from the Robert Wood Johnson Foundation.

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Dual Eligibles

ABOUT THIS BRIEF Dual enrollees in Medicare and Medicaid are among the poorest, sickest and highest users of health-care services in the United States. Yet they face numerous difficulties in coordinating benefits between these programs. In this brief we look at who the dual enrollees are and offer tips as to how you can help your clients maximize their benefits. *Special thanks to our guest author, Patricia Nemore of the Center for Medicare Advocacy.*

About seven million people are dually enrolled in Medicare and Medicaid. About six million of these dual enrollees[1] receive full Medicaid-covered services; the remaining one million receive Medicaid assistance only with Medicare cost-sharing. Dual enrollees are among the poorest, sickest and highest users of health-care services in the United States. For those receiving full Medicaid, Medicare is the primary insurer and pays for most hospitalization and medical services. Medicaid pays for some or all of Medicare's cost-sharing and for services such as prescription drugs and non-skilled long-term care that Medicare does not cover.

Like other people with two forms of coverage, such as families covered under both spouses' employer-based health plans or Medicare beneficiaries who also receive retiree health benefits, dual enrollees may experience difficulties coordinating benefits between the two sources of coverage. But because they are frailer, more disabled and sicker than much of the rest of the population, dual enrollees often find coordination issues to be a major barrier to getting needed health-care services. Moreover, because of Medicaid's requirement that benefits must be recovered from the estates of deceased beneficiaries, dual enrollees benefit from maximizing Medicare coverage so as to limit their recovery liability.

States are concerned about how much dual enrollees cost to serve under their Medicaid programs, because Medicaid's portion of the cost of serving dual enrollees is increasing. Between 1984 and 1998, the ratio of Medicare to Medicaid payments for dual enrollees changed from 70/30 to 60/40. It is expected to be 55/45 by 2012.[2] This shift arises in part from changes in medical practice away from Medicare-covered hospitalization and toward prescription drug therapies, which to date have only been paid for by Medicaid. The resulting increasing budget responsibility is alarming to states and tends to lead them to look for ways to limit costs, resulting in additional barriers to beneficiaries seeking services.

In this brief, we will look at the differences between the two programs, highlight issues raised by those differences and discuss how you can help your dually enrolled clients maximize appropriate coverage from both programs. The brief focuses on coordination issues between Medicare Parts A and B and fee-for-service Medicaid. It does not address the more limited, but complex, issues of coordination between Medicare+Choice (renamed Medicare Advantage by the Medicare Prescription Drug Improvement and Modernization Act of 2003) and Medicaid. Nor does it address issues related to prescription drug coverage for dual enrollees that arise from provisions of this Act, which will not be effective until 2006.[3] Finally, the dually-enrolled beneficiaries who are the subject of this brief are those who have full Medicaid coverage, rather than only assistance with Medicare cost-sharing.

Who are the dual enrollees?

Dual enrollees have very low incomes. Nearly three-quarters have incomes under $10,000 (just above the poverty level), compared to 13 percent of other Medicare beneficiaries. They are dramatically different from other Medicare beneficiaries in other respects as well. For example, approximately one-quarter of them reside in nursing facilities, compared with only two percent of other people with Medicare. They are twice as likely to report being in fair or poor health as other beneficiaries and have significant limitations in activities of daily living at more than twice the rate of other beneficiaries. Six percent of dual enrollees have Alzheimer's disease as compared with three percent of other Medicare beneficiaries. They are more likely to have other chronic conditions, such as diabetes and stroke, as well.[4]

Both Medicare and Medicaid resources are disproportionately spent on dual enrollees. These beneficiaries comprise 18 percent of all Medicare beneficiaries, but use 24 percent of all Medicare dollars. On the Medicaid side, they make up 16 percent of Medicaid enrollees and use 42 percent of all Medicaid dollars.[5]

What causes coordination difficulties for dual enrollees?

Coordination issues arise because of several elements in the structures of the two programs: different definitions of medical necessity; different coverage rules for similar services; and the requirement that Medicaid is the payer of last resort and must seek reimbursement from all liable third parties, including Medicare. Moreover, the programs have different appeals systems, and it is often not clear how someone should proceed in challenging the denial or reduction of a service. Unfortunately, states often fail to provide clear guidance to dual enrollees to help them navigate these complex systems.

MEDICAL NECESSITY DEFINITION

Medicare pays for covered services that are medically "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."[6] Medicare has long been viewed as a program designed on a medical model of health insurance; its limitation of long-term care coverage to skilled services, for example, supports that view. Medicaid's reach is longer, however, and makes it better suited to meet the needs of people with disabilities who need certain services to allow them to participate fully in independent life. The federal Medicaid statute describes the program as paying for "necessary medical services and...rehabilitation and other services to help...individuals attain or retain capability for independence or self-care."[7]

Medicare's medical necessity definition has been interpreted in federal regulations, manuals and court decisions. Medicaid's definition is subject to different federal regulations, manuals and court decisions. In addition, in any given state, Medicaid's definition may also be affected by the state constitution, state statutes, regulations and court decisions at both the federal and state court level. Thus, while there is a single medical necessity definition for Medicare, there is a different one for every state Medicaid program.

States do not always acknowledge their responsibility to make independent medical necessity determinations for dual enrollees seeking services that are covered by both Medicare and Medicaid. They may, in fact, tell dual enrollees that if Medicare does not pay for a certain item or service, Medicaid will not pay for it either, despite the fact that Medicaid beneficiaries without Medicare coverage will be entitled to coverage.

An example:

In November 2003, the state of Connecticut *did* acknowledge its responsibility to make independent determinations concerning Durable Medical Equipment (DME) in Provider Bulletin 2003-113. Noting that Connecticut's definition of Durable Medical Equipment is identical to the one used by the Centers for Medicare and Medicaid Services in its administration of the Medicare program, the bulletin further states that "one of the purposes of the Medicaid program is to enable each state, in accordance with all applicable statutory and regulatory requirements, to furnish rehabilitation and other services to help eligible families and individuals attain or retain capability for independence or self-care."

Moreover, "while the (Medicare) Manual provides broad guidance for which items meet the definition of DME and when such items can be determined to be medically necessary and/or medically appropriate for an individual client, it is never the sole basis for denial of a request for coverage. It is a reference point, but it is just that."

If your dually-enrolled clients are having difficulty getting services that other Medicaid beneficiaries are able to use, you can ask your state Medicaid agency to make a coverage determination independent of Medicare, using all the state's medical necessity guidelines. If the agency is unwilling to do so, you can request a fair hearing through the Medicare appeals process. You are supported in this request by federal Medicaid requirements that services must be comparable for all Medicaid beneficiaries, regardless of their other coverage.

COVERAGE RULES

The area in which distinctions in coverage rules are most prominent is long-term care: both institutional and community-based services.

Skilled Nursing Facility Services vs. Nursing Facility Services

Medicare pays for skilled nursing or rehabilitative care, following a three (or more) day hospitalization for a condition related to the hospitalization. The care must be provided in a certified skilled nursing facility, and coverage is available for up to 100 days (although most people receive much less).[8] After the 20th day, your client must pay a copayment ($109.50 in 2004). ***Medicaid*** pays for nursing or rehabilitative care that can only be provided in a nursing facility on an inpatient basis. A "nursing facility" under Medicaid is a place that provides "health related care and services." The care must be provided in a certified nursing facility and there is no limit on the number of days of coverage as long as the services are medically necessary. Medicaid requires the individual to pay a "share of cost" that comprises the individual's whole monthly income less certain required and permitted deductions (such as an amount for personal needs and another for supporting a spouse or dependents, if applicable). Medicaid then pays the facility the difference between the individual's share of cost and the Medicaid rate.

Facility certification: Difficulties can arise for your dually enrolled clients because facilities may not be certified for both Medicare and Medicaid or may have separate wings certified for each program.[9] If your client enters the facility with Medicaid paying for the stay and is subsequently hospitalized for three days, he or she will then be eligible for a period of skilled nursing coverage under Medicare. Your client may be told—either by the facility or by the state Medicaid program—that he or she cannot return to the Medicaid bed but must be placed in a bed in a Medicare-only-certified portion of the facility. The facility might tell your client this if it will receive a higher reimbursement rate under Medicare than Medicaid, and the state might try to force him or her to get Medicare coverage because of its obligation under federal law to seek reimbursement from all liable third parties.

Under the law, however, if the old bed is available, or another one in the same vicinity as the old bed, the facility must readmit your client to it, regardless of whether it can get higher reimbursement if he or she is in a bed in a Medicare-certified portion of the facility. Moreover, with respect to the state's concern about third party liability, the Centers for Medicare and Medicaid Services has said on at least one occasion that states are required to seek third party coverage only where such coverage exists. If a resident is in a bed in a portion of a facility not certified for Medicare, there would be no Medicare coverage for that bed.[10]

Conversely, your dually enrolled client might enter the facility for the first time needing skilled care after a three-day hospitalization, and so be entitled to Medicare coverage right away. When that coverage ends, your client may be told by the facility that he or she must move because it needs the bed for another Medicare resident. While the law gives your client an absolute right to refuse this transfer, he or she will not be able to get Medicaid to pay for the continued stay unless the bed is also certified for Medicaid.

As a general matter, when a facility asks your client to move from one part of the facility to another, it is a good idea to find out what the certification is for both parts of the facility. If they are certified differently—e.g., one is only Medicare-certified and the other is only Medicaid-certified—your client is entitled to a notice of the reasons for the transfer and an opportunity for a fair hearing to challenge the transfer.[11] If the move is merely from one room to another within a certified portion of the facility, your client is entitled only to notification, not to a hearing, but may be able to prevent the relocation by invoking federal standards that promote self-determination, participation and accommodation of the resident's needs.

Share of cost: If your dually-enrolled client's nursing home stay is paid for by Medicaid, she will pay all of her income—less deductions allowed for personal needs, the support of family members and a few other purposes—to the facility as her share of cost (also called Net Available Monthly Income, patient pay amount or applied income). Medicaid then pays the difference between the share of cost and the established Medicaid rate for the facility.

However, when a portion of her stay is paid for by Medicare, different rules apply. If your client is a Qualified Medicare Beneficiary (income is less than 100 percent of federal income poverty guidelines, currently about $9,000 per year for one person)[12], she should have no share of cost for any portion of her nursing home stay that is covered by Medicare. This is because Medicare will cover fully the first twenty days of her Medicare-covered stay, and the co-payment ($109.50 for 2004) for days 21-100 is Medicaid's responsibility. The nursing home can neither charge her for the co-payment, nor receive her Medicaid share of cost for that period of time.

Home Health Services

Medicare covers part-time and intermittent skilled nursing services; physical, speech and occupational therapy services; medical social services; and non-skilled home health aide services incidental to the provision of skilled services, when your client needs intermittent skilled nursing services or therapy services. To be eligible for such services, your client must be homebound, meaning that it requires a considerable and taxing effort for him or her to leave the house. While the interpretation of "homebound" has been liberalized in recent years, it continues to be a barrier for beneficiaries to receive Medicare home health services. Also, Medicare home health nursing and aide services are limited to a maximum of 35 hours per week combined[13]; often coverage is for significantly fewer hours.[14] (For more information about Medicare coverage of long-term care services, see Issue Brief Volume 4 Number 4 available on our Web site at www.MedicareEd.org.)

Medicaid home health services must include part-time or intermittent nursing services, home health aide services, and medical supplies, equipment and appliances suitable for use in the home. The state may, however, choose whether to cover physical or occupational therapy, speech pathology and audiology services. Both Medicare and Medicaid require that home health services are provided by certified home health agencies.

In contrast to Medicare, Medicaid requires neither that the services needed are skilled nor that the client is homebound. In fact, according to the Centers for Medicare and Medicaid Services, a homebound requirement for Medicaid home health services violates several Medicaid regulations and is impermissible. Moreover, unlike the Medicare statute, federal Medicaid law places no limit on the number of hours of service that can be covered.

Medicaid care coordinators serving dually-enrolled beneficiaries sometimes ignore Medicare as a source of home health services because the skilled and homebound requirements restrict the services, because home health agencies may erroneously inform beneficiaries that Medicare will not cover their care, and/or because challenging those decisions may seem cumbersome. In such circumstances, however, you can help your client by advocating for Medicare coverage up to the maximum allowable hours. The benefits of such advocacy are at least two-fold: your client may be able to get more home health services by relying on coverage provided by both programs than he or she would get under either program individually, and to the extent the services are covered by Medicare, your client will not have estate recovery liability under Medicaid.

Third Party Liability

Your dually-enrolled clients may discover that Medicaid refuses to pay for an item or service until they have sought Medicare coverage for it. This refusal is referred to as cost avoidance; it derives from Medicaid's status as payer of last resort and its responsibility to seek coverage from all liable third parties. The Centers for Medicare and Medicaid Services directs states to use cost avoidance unless they have a waiver that allows them to "pay and recover later." Under the pay and recover later model, states pay claims for Medicaid-covered services, then seek reimbursement from any liable third parties, including Medicare. From a dual enrollee's perspective, this is probably the most advantageous approach, although it is rarely used for this population.[15]

A third approach to coordination of payment is acceptable in situations where "probable" third party coverage is not established at the time of the claim, but is discovered after Medicaid has already paid. In those situations, the Medicaid agency is directed to seek the third party payment, if doing so is cost effective. If a provider believes Medicare will not cover a certain service (e.g., home health care because the provider believes the beneficiary will not meet the "homebound" definition), it may submit a reimbursement request directly to Medicaid. In some states, the Medicaid agency will reimburse the provider then review the claim to determine if there may, in fact, be third-party coverage.

Appeals

Medicare and Medicaid have entirely separate appeals systems. Unfortunately, it is not possible to have issues in both programs completely resolved in a single appeal. The most that can be resolved is whether there is coverage under the program in whose appeals system your client is operating.

To pursue an appeal in Medicare, a beneficiary must have received the service for which coverage is sought and thus must incur the expense of the service without knowing if Medicare reimbursement will be made. To incur such an expense is a substantial risk if not impossible for dual enrollees who are, by definition, poor or near poor. Current law allows a Medicare beneficiary who has received an Advance Beneficiary Notice of non-coverage from a provider to request that a demand bill be submitted to Medicare to determine whether Medicare will cover the service. The beneficiary is not required to pay prior to the initial determination of coverage, but then may be liable if coverage is denied. (For more information about the Medicare appeals process, see Issue Brief Volume 3 Number 4 available on our Web site at www.MedicareEd.org). Even while pursuing the next level of appeal in Medicare, you can help your client by seeking Medicaid coverage for the same service.

Medicaid agencies may seek to limit their responsibility for Medicare-covered services to any co-insurance amount for which your client would otherwise be liable. For example, if, as is common, Medicare pays a lower amount for a wheelchair, Medicaid may not acknowledge its responsibility to make an independent Medicaid determination of coverage that would assure that a wheelchair supplied would meet your clients needs. The Medicaid agency may claim there is no denial of coverage subject to a Medicaid appeal because they intend to pay the Medicare co-insurance. You can help your clients by asserting their right to a Medicaid fair hearing and insisting on an independent medical necessity and coverage determination under Medicaid rules. For more help with appeals and other Medicare and Medicaid advocacy issues, contact your local legal aid society or state health insurance assistance program (SHIP). To find the SHIP in your area, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov and click on "Helpful Contacts."

In Conclusion

The issues facing dually-enrolled clients are more complex than those for individuals with a single source of coverage. However, dual enrollment provides the promise of greater coverage for this very needy population, since each program covers goods and services not included in the other program. While you might meet resistance from your state Medicaid agency when you assert your clients' rights under that program, you will find that understanding the source of the problems that arise will help you articulate the position most favorable to your clients.

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[1] Dual enrollees are sometimes also called dual eligibles. The term enrollee is more accurate, however, since it describes their status as *participating* in both Medicare and Medicaid. Due to many factors beyond the subject of this brief, many people who are *eligible* for both programs are not enrolled in one or the other.

[2] Ku, L. (2003). *Shift In Costs From Medicare To Medicaid Is A Principal Reason For Rising State Medicaid Expenditures*, http://www.cbpp.org/3-3-03health.htm

[3] Under the provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003, for the first time since passage of Medicare and Medicaid, dual enrollees will be prevented from receiving "wrap around" drug coverage from

Medicare. That is, in instances where their Medicare drug plan does not cover a specific drug, dual enrollees will not be able to turn to Medicaid for assistance.

[4] The Kaiser Family Foundation. (2004). *Dual Eligibles: Medicaid's Role for Low-Income Beneficiaries.* http://www.kff.org/medicaid/ loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30741.

[5] The Kaiser Family Foundation. (2004). *Dual Eligibles: Medicaid's Role for Low-Income Beneficiaries.* http://www.kff.org/medicaid/ loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30741.

[6] 42 U.S.C. § 1395y(a)(1)(A)

[7] 42 U.S.C. § 1396

[8] Centers for Medicare and Medicaid Services, *Program Information on Medicare, Medicaid, SCHIP, and Other Programs of the Centers for Medicare and Medicaid Services (Section IIID),* http://www.cms.hhs.gov/charts/series/sec3-D.pdf.

[9] Facilities' decisions to limit participation in one or both programs by certifying only a portion of the facility are generally made for financial reasons. At least with respect to Medicare, financial incentives for partial certification have changed in recent years due to the introduction of prospective payment systems for skilled nursing facility reimbursement. The new system substantially reduces the advantage of partial certification; it is unclear whether facility certification behavior has caught up with the new incentive realities, but to the extent that it does, dual enrollees will benefit from having greater choice of beds.

[10] Letter of March 31, 1999 from Associate Regional Administrator, Region I, Health Care Financing Administration (precursor to the Centers for Medicare and Medicaid Services) to Center for Medicare Advocacy, Inc.

[11] Federal law limits the permissible reasons for transfers. The reasons, which apply to all nursing home residents, not just to those dually enrolled, are: 1) the resident's welfare cannot be met by the facility, 2) the resident no longer needs the facility's services because of improved health, 3) the safety of individuals in the facility is endangered, 4) the health of individuals in the facility would be endangered 5) the resident has failed to pay and 6) the facility ceases to operate. In addition, your client can refuse a transfer to or from a Medicare-certified portion of the facility when the purpose is to relocate him or her from or to a non-Medicare certified portion of the facility.

[12] 68 F.R. 6456 (February 7, 2003).

[13] 42 U.S.C. § 1395x(m)

[14] Centers for Medicare and Medicaid Services, *Program Information on Medicare, Medicaid, SCHIP, and Other Programs of the Centers for Medicare and Medicaid Services (Section IIID),* http://www.cms.hhs.gov/charts/series/sec3-D.pdf.

[15] Medicaid claims for prenatal care for pregnant women and for preventive pediatric services must, by statute, be paid on a pay and recover later basis. Getting health care coverage would be much easier for dual enrollees if all their claims were paid on that basis, as well.

About the Author

Patricia Nemore, an attorney with the Center for Medicare Advocacy, Inc., has been an advocate for older people and people with disabilities seeking health care for more then 20 years. Her practice has focused on Medicare, Medicaid and long-term care, with special emphasis on issues of importance to those dually eligible for Medicare and Medicaid. She has engaged in individual advocacy, class action litigation and legislative and administrative advocacy at the national level. She graduated from the Columbus School of Law of the Catholic University of America.

The Center for Medicare Advocacy, Inc., founded in 1986, is a national, non-partisan education and advocacy organization that identifies and promotes policy and advocacy solutions to ensure that elders and people with disabilities have access to Medicare and quality health care. The organization provides training regarding Medicare and health-care rights throughout the country and serves as legal counsel in litigation of importance to Medicare beneficiaries nationwide. The organization's national office is in Connecticut, with offices throughout the country, including in Washington, DC. For more information about the Center for Medicare Advocacy, Inc., visit www.medicareadvocacy.org.

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The Medically Indigent

Qualified Medicare Beneficiaries (QMB)

Medicare Part A beneficiaries

Income at or below 100% FPL

Resources at twice the SSI resource standard

This coverage cannot begin until the month following the month in which eligibility is determined.

Medicaid covers only the Medicare premiums, deductibles and co-insurance payments

Specified Low-Income Medicare beneficiaries (SLMBs)

Meet all QMB requirements except income

Income between 100% and 120% FPL

Medicaid pays Medicare Part B premium only

Qualifying Individuals (QI-1s)

Meet all QMB eligibility requirements except income

Income between 120% and 135% FPL

Medicaid pays Medicare Part B premium only.

QI-1 coverage is limited by the availability of funds.

Qualified Disabled and Working Individuals

Working disabled individuals who lose their extended Medicare coverage after a "trial work period" of 48 months.

Income at or below 200% FPL

Resources at or below twice the SSI standard

Medicaid covers only their Medicare Part A premiums.

SELECTED INCOME AND RESOURCES LEVELS (2/04)

Medically Needy Income Levels (rounded from M0710, Appendix 5)

Family Size	Group I		Group II		Group III	
	1 mo.	6 mos.	1 mo.	6 mos.	1 mo.	6 mos.
1	$230	$1380	$265	$1592	$345	$2071
2	293	1758	326	1962	416	2497
3	345	2070	381	2283	469	2814
4	389	2336	425	2549	513	3080

SSI Benefits	Individual	$564 / month	$2,000 resource limit
	Couple	846 / month	$3,000 resource limit

ABD Medicaid Categories

Low Income Aged & Disabled 80% Poverty Line	Individual $621, Couple $833 SSI Resource Level
Qualified Medicare Beneficiary 100% Poverty Line	Individual $776, Couple $1,041 Twice SSI Resource Level
Specified Low Income Medicare Beneficiary 120% Poverty Line	Individual $931, Couple $1,249 Twice SSI Resource Level
Qualified Individual - 1 135% Poverty Line	Individual $1,048, Couple $1,406 Twice SSI Resource Level
Qualified Disabled Working Individuals 200% Poverty Line	Individual $1,552, Couple $2,082 Twice SSI Resource Level
Long Term Care (NH or CBC) 300% SSI	Individual $1,692 SSI Resource Level

COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: AAA Directors

FROM: Bill Peterson

DATE: April 13, 2004

SUBJECT: **Adult Protective Services Update**

Just a reminder that although this year's legislature could not pass a budget, it did manage to pass what our colleagues in DSS are calling a “landmark bill” updating the APS section of the Code of Virginia. A summary is attached, as well as a new listing of mandated reporters which takes effect 7/1/04. To see the complete text of the two APS bills, go to http://leg1.state.va.us/042/bil.htm and enter "sb318" or "hb952" in the search area. Commissioner DeBoer worked with DSS, Secretary Woods, and the legislature on these bills.

I have also attached a new report on the *Evaluation of the Virginia Financial Institution Reporting (FIR) Project*. Between FY 2002 and FY 2003 (pre- and post-implementation of the project), there was close to a 300 percent increase in the number of financial exploitation reports made by all sources. This is a significant increase in the number of financial exploitation reports for Virginia. In addition, close to 1,000 financial institution staff and others have been trained on detecting possible exploitation and what to do about it. I believe the FIR project motto is: Remember, stopping financial exploitation stops a crime and, it's the right thing to do.

Attachments (3)

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SUMMARY OF ADULT PROTECTIVE SERVICES (APS) ENROLLED BILL (SENATE BILL 318/HOUSE BILL 952)

Senate Bill (SB) 318 and House Bill (HB 952) amend the *Code of Virginia* at § 63.2-1603 through 1610 regarding Adult Protective Services (APS) by:

1) Clarifying population served and adding that reports of suspected abuse, neglect, or exploitation may be made to the local department of social services (local department) OR the 24-hour, toll-free APS hotline;
2) Requiring local departments to initiate an investigation within 24 hours of the report and clarifying what is meant by a "valid" report;
3) Requiring the local department to refer matters as appropriate to the appropriate licensing, regulatory, or legal authority for administrative action or criminal investigation;
4) Allowing the local departments, with informed consent, to take or cause to be taken photographs, video recordings, or appropriate medical imaging of the adult and his environment that are relevant to the investigation;
5) Clarifying that APS will not investigate in state correctional facilities;
6) Expanding the list of APS situations in which law enforcement must be notified to include sexual abuse; death, serious bodily injury or disease believed to be caused by abuse or neglect; and any other criminal activity involving abuse or neglect that places the adult in imminent danger of death or serious bodily harm;
7) Changing the timeframe for reporting of suspected adult abuse, neglect, or exploitation by mandated reporters to "immediately" except reports by nursing facility inspectors employed by the Department of Health in the course of a survey;
8) Adding persons to the list of APS mandated reporters;
9) Noting that a mandated reporter providing professional services in a hospital, nursing facility, or similar institution may, in lieu of reporting directly to APS, notify the person in charge, who shall report such information immediately upon determination that there is reason to suspect abuse, neglect, or exploitation;
10) Adding accounting firms to the list of financial institutions who may report voluntarily;
11) Prohibiting employers of mandated reporters from preventing a mandated reporter to report directly to APS;
12) Requiring employers of mandated reporters to ensure that employees are notified that they are mandated reporters and trained on reporting responsibilities;
13) Adding criminal penalties for persons 14 years of age or older who make a false report;
14) Authorizing the Commissioner of the Department of Social Services to impose civil money penalties for cases of non-reporting by all mandated reporters except law-enforcement officers (the courts would take these cases);
15) Requiring mandated reporters to report immediately to the appropriate medical examiner and law-enforcement agency when there is reason to suspect that an adult died as a result of abuse or neglect and authorizing the medical examiner to order an autopsy;
16) Relieving a mandated reporter from reporting to APS if he has actual knowledge that the same matter has already been reported;
17) Requiring all law-enforcement departments and other state and local departments, agencies, authorities, and institutions to cooperate with APS in the detection, investigation, and prevention of adult abuse, neglect, and exploitation;
18) Allowing APS to be provided through an appropriate court order for a period of 15 days (instead of 5);
19) Requiring the Department of Social Services to develop a plan and cost estimate by November 1, 2004, to prepare, disseminate, and present educational programs and materials on adult abuse, neglect, and exploitation to all categories of newly mandated reporters and that the penalty provisions shall not apply to newly mandated reported until the delivery of such training; and
20) Requiring the Department of Social Services to develop a model protocol and procedures for, as well as cost estimates for the operation of, adult fatality review teams by November 1, 2004.

MANDATED REPORTERS FOR ADULT PROTECTIVE SERVICES

***Code of Virginia*, § 63.2-1606(A) -** Effective July 1, 2004

- **Any person licensed, certified, or registered by health regulatory boards listed in § 54.1-2503, except persons licensed by the Board of Veterinary Medicine:**

  Board of Nursing: Registered Nurse (RN); Licensed Nurse Practitioner (LNP); Licensed Practical Nurse (LPN); Clinical Nurse Specialist; Certified Massage Therapist; Certified Nurse Aide (CNA)

  Board of Medicine: Doctor of Medicine and Surgery, Doctor of Osteopathic Medicine; Doctor of Podiatry; Doctor of Chiropractic; Interns and Residents; University Limited Licensee; Physician Assistant; Respiratory Therapist; Occupational Therapist; Radiological Technologist; Radiological Technologist Limited; Licensed Acupuncturists; Certified Athletic Trainers

  Board of Pharmacy: Pharmacists; Pharmacy Interns; Permitted Physicians; Medical Equipment Suppliers; Restricted Manufacturers; Humane Societies; Physicians Selling Drugs; Wholesale Distributors; Warehousers, Pharmacy Technicians

  Board of Dentistry: Dentists and Dental Hygienists Holding a License, Certification, or Permit Issued by the Board

  Board of Funeral Directors and Embalmers: Funeral Establishments; Funeral Services Providers; Funeral Directors; Funeral Embalmers; Resident Trainees; Crematories; Surface Transportation and Removal Services; Courtesy Card Holders

  Board of Optometry: Optometrist

  Board of Counseling: Licensed Professional Counselors; Certified Substance Abuse Counselors; Certified Substance Abuse Counseling Assistants; Certified Rehabilitation Providers; Marriage and Family Therapists; Licensed Substance Abuse Treatment Practitioners

  Board of Psychology: School Psychologist; Clinical Psychologist; Applied Psychologist; Sex Offender Treatment Provider; School Psychologist - Limited

  Board of Social Work: Registered Social Worker; Associate Social Worker; Licensed Social Worker; Licensed Clinical Social Worker

  Board of Nursing Home Administrators: Nursing Home Administrator

  Board of Audiology and Speech Pathology: Audiologists; Speech-Language Pathologists; School Speech-language Pathologists

  Board of Physical Therapy: Physical Therapist; Physical Therapist Assistant

- **Any mental health services provider as defined in § 54.1-2400.1;**

- **Any emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5;**

- **Any guardian or conservator of an adult;**

- **Any person employed by or contracted with a public or private agency or facility and working with adults in an administrative, supportive or direct care capacity;**

- **Any person providing full, intermittent, or occasional care to an adult for compensation, including but not limited to companion, chore, homemaker, and personal care workers; and**

- **Any law-enforcement officer.**

REPORT ON

EVALUATION OF THE VIRGINIA FINANCIAL INSTITUTION REPORTING (FIR) PROJECT

**TO THE HONORABLE PHILLIP HAMILTON,
COMMISSIONER OF THE DEPARTMENT OF SOCIAL SERVICES,
AND THE VIRGINIA FIR PROJECT ADVISORY COMMITTEE**

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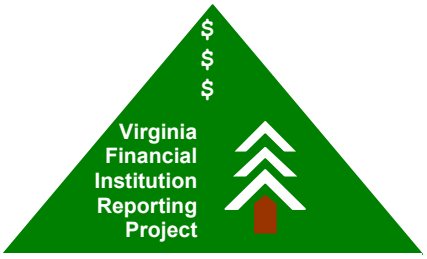
APRIL 2004

VIRGINIA FINANCIAL INSTITUTION REPORTING (FIR) PROJECT EVALUATION



VIRGINIA DEPARTMENT OF SOCIAL SERVICES
ADULT SERVICES PROGRAM

Introduction

Senior citizens and persons with a disability are targeted for financial exploitation because they are often socially isolated or dependent on others for assistance. Exploitation can take the form of a con artist, a bogus charity, an unscrupulous contractor, or even a family member, caregiver, or acquaintance. Whatever form it takes, financial exploitation often surfaces in financial institutions and can result in the depletion of a victim's lifetime savings. Woody Guthrie once said, *"Some rob you with a gun, some with a fountain pen."*

Financial institutions are in the position to have early (and often the only) knowledge of ongoing financial exploitation of vulnerable adults. Employees build relationships with customers they see frequently or have known for a long time. They are on the front lines to notice possible financial exploitation of vulnerable persons by relatives, friends, and acquaintances. They are also well informed about quick scams by con artists and consumer fraud. Financial institution staff administers accounts, trusts, and other financial assets, possessing knowledge that is invaluable in advising customers about protecting assets.

In Virginia, Adult Protective Services (APS) investigates allegations of suspected adult abuse, neglect, and exploitation for persons aged 60 and over and for adults who are incapacitated aged 18 and over without regard to income. Services are provided through 120 local departments of social services and administered by the Virginia Department of Social Services (the Department), Adult Services Program.

Legislation Patroned by the Honorable Phillip A. Hamilton

The 2001 Session of the Virginia General Assembly passed House Bill 1581, sponsored by the Honorable Phillip A. Hamilton, which stated that financial institutions that suspect that an adult customer has been exploited financially may report such exploitation to local adult protective services without criminal or civil liabilities. The *Code of Virginia*, § 63.2-1606(D) reads:

> *Any financial institution that suspects that an adult customer has been exploited financially may report such suspected exploitation to the local department of the county or city wherein the adult resides or wherein the exploitation is believed to have occurred. Such a complaint may be oral or in writing. For purposes of this section, a financial institution means any bank, saving institution, credit union, securities firm, or insurance company.*

The Virginia FIR Project

In response to Mr. Hamilton's legislation (House Bill 1581, 2001) and growing concerns that financial institution personnel were seeing evidence of customer exploitation, but not recognizing it or being aware of what to do about it, the Department collaborated with community partners and stakeholders to develop training and educational materials for financial institutions to report suspected adult financial exploitation. The project was designed to educate financial institution personnel about the indicators of financial exploitation, their reporting responsibilities, and the role of APS and law enforcement in protecting the customer from further abuse and in seeking restitution.

The Virginia Financial Institution Reporting (FIR) Advisory Committee was convened in March 2001 and met several times throughout the year to discuss the problem of adult financial exploitation and to recommend ways to educate the public about recognizing and preventing financial exploitation. Experts from Oregon came to an advisory committee meeting and outlined a successful financial exploitation prevention project implemented by that state. The advisory committee developed a tool kit to be used statewide by a variety of organizations. Existing programs from Oregon, Massachusetts, and the Tidewater Financial Exploitation Action Team (FEAT) were considered as model programs. The tool kit, which received national recognition as a model program, was finalized in April 2002. It includes:

- The *Virginia Financial Institution Reporting (FIR) Project Resource Guide;*
- Brochures for seniors and adults with disabilities;
- Brochures for financial institutions;
- Videotape (based on Oregon's videotape on financial exploitation);
- PowerPoint presentation with speaker's guide and answers to frequently asked questions; and
- Quick reference posters.

The Adult Services Program is pleased to have had the support of many organizations in developing this educational campaign, including AARP, Offices of the Secretary of Health and Human Resources and Attorney General, Better Business Bureau of Central Virginia, Virginia Bankers Association, Virginia Credit Union League, Virginia Securities Association, financial exploitation projects in Oregon and Massachusetts, other financial institution representatives, and local departments of social services.

National Elder Abuse Incidence Study

The National Elder Abuse Incidence Study (NEAIS), conducted in 1996 with funding from the U.S. Administration on Aging and Administration on Children and Families, provides a snapshot of the number of new adult abuse cases that occurred in 1996. Some of the general findings from the NEAIS indicate that:

- Persons age 80 and older are abused and neglected at a rate two to three times higher than their percentage in the general population.
- Female elders are abused at a higher rate than males.

- Of those older persons about whom reports of abuse or neglect were substantiated by APS, almost half were not physically able to care for themselves.
- In almost nine out of ten incidents of domestic elder abuse and neglect, the perpetrator is a family member; adult children are responsible for almost half of elder abuse and neglect cases.
- Reported cases represent "the tip of the iceberg," with between four and five times as many incidents of abuse and neglect going unreported as are reported to APS.

In the communities studied for the NEAIS, reports to APS about "financial/material exploitation" accounted for 30 percent of all substantiated reports. Friends, neighbors, hospitals, and family members were the most frequent reporters. Financial abuse was substantiated in 45 percent of the investigations conducted by APS.

The NEAIS findings revealed that the likelihood of becoming a victim of financial abuse increases with age. Almost half (48 percent) of the victims of financial abuse were aged 80 or older, with another 29 percent between the ages of 75 and 79. The percentages dropped to 11 percent for victims between age 70 and 74, 9 percent for those between age 65 to 69, and 3 percent for those between age 60 and 64.

INCIDENCE OF FINANCIAL EXPLOITATION BY AGE (60 and older)

AGE OF VICTIM	PERCENTAGE
80 and older	48%
75-79	29%
70-74	11%
65-69	9%
60-64	3%

An interesting and, to some, surprising finding is that the likelihood of financial abuse does not increase with higher levels of income. In the cases where APS workers were able to estimate or determine the victim's income, 46 percent had incomes between $5,000 and $9,999; 30 percent had incomes between $10,000 and $14,999; and 22 percent had incomes of $15,000 or more.

The study indicated that females are especially vulnerable to financial abuse. Females were victimized at a rate "somewhat more" than their proportion of the older population (63 percent of adults financially abused vs. 58 percent of the older population). Males were financially abused in 37 percent of the cases.

Another interesting finding was that perpetrators of financial abuse were more likely to be young. Approximately 45 percent of the perpetrators were age 40 or younger, 40 percent of them were between the ages of 41 and 59, 4 percent were between ages 60 and 69, and 2 percent were between the ages of 70 and 79. Surprisingly, 10 percent of the perpetrators were older than 80.

Finally, the study concluded that perpetrators of financial abuse were most likely to be the adult children (60 percent) of the victims. The victims' "other relative[s]," "grandchild[ren]," and

"friends/neighbors" were almost equally as likely to be perpetrators (10 percent, 9 percent, and 9 percent respectively) (Stiegel, L., 2000).

Training to Financial Institutions and Others

Among the local departments of social services, 15 localities (13 percent) reported conducting specific financial exploitation training for financial institutions. Seventeen training sessions specifically for financial institutions were held by local departments of social services with a total of 164 persons trained. Local departments participated in public awareness campaigns for the annual Adult Abuse Awareness Month in May of each year, which included information on financial exploitation and how to recognize it.

Training has been provided to financial institution staff, community and civic groups, students, and other interested persons by other entities, including state and regional VDSS staff and representatives from the Tidewater Financial Exploitation Action Team (FEAT). Trainings that have been offered include, but are not limited to, the following:

PRESENTATIONS TO FINANCIAL INSTITUTIONS AND OTHERS

DATE	TRAINING	# OF PARTICIPANTS
FY 2003	Various trainings by local departments of social services	164
January 2004	Customer service managers from Bank of America	44
January 2004	Chambers of Commerce for Isle of Wight and Accomack Counties	25
October 2003	Presentation to Long-Term Care Ombudsmen Statewide Meeting/Richmond	40
April 2003	Virginia Bankers Association Security Workshop Meeting	85
March 2003	Longwood University intern working with Bedford DSS is making presentations and providing materials to banks in the county on financial exploitation	30
March 2003	Virginia FIR Project materials shared with gerontology professor at Longwood University	N/A
January 2003	Presentation to Adult Services Program Coordinators in the Central Region	30
November 2002	Virginia Beach Mayor's Conference, Virginia Beach Mayor's Commission on Aging	80
November 2002	Presentation at Elder Abuse and Neglect Workshop/Lynchburg College	30
October 2002	Presentation to Long-Term Care Ombudsmen Statewide Meeting/Richmond	40
October 2002	Presented workshop the National Aging and Law Conference in Arlington	20
September 2002	Presentations at Elder Abuse Symposium at Elks' Lodge in Bedford to academicians, seniors, local department of social services staff, students, and other interested persons	50
September 2002	Training to Department of Health nursing facility surveyors	50
April 2002	FEAT training in Virginia Beach	20
April 2002	Virginia Credit Union League Annual Meeting/Reston	150
April 2002	Virginia Bankers Association Security Workshop/Charlottesville	85
April 2002	Tidewater Regional Credit Union meeting/Chesapeake	40
	KNOWN TOTAL # OF PERSONS TRAINED	**983**

Since the implementation of the Virginia FIR Project in April 2002, close to 1,000 persons are known to have been trained on recognizing adult financial exploitation and how to report to APS. It is anticipated that many more have been trained, but not reported to the home office. Local financial institutions are encouraged to coordinate with APS in local departments of social services to provide training on recognizing and reporting suspected cases of adult financial exploitation.

Distribution of Tool Kits

Close to 500 tool kits have been distributed statewide to local departments of social services, area agencies on aging, selected financial institutions and law-enforcement offices, the Better Business Bureau, and AARP. Tool kits are also available for the cost of printing to anyone who requests them, including financial institutions. To date, close to 80 tool kits have been purchased by financial institutions and other organizations. Payments received for these tool kits have gone back into the Adult Services Program's budget to help defray the cost of production.

National Recognition

CANE (Clearinghouse on Abuse and Neglect of the Elderly) is the nation's largest and most utilized computerized collection of elder abuse materials and resources. With over 3,000 holdings, CANE has the ability to perform customized searches of over 100 keywords producing annotated bibliographies available to the professional community and to the public. CANE is a service of the National Center on Elder Abuse (NCEA), which is supported by the U.S. Administration on Aging. The Virginia FIR Project was accepted as part of CANE's "Promising Practices" program of the National Center on Elder Abuse and is available on its website.

The Virginia FIR Project was chosen to be a workshop at the 2002 National Aging and Law Conference held in Arlington, Virginia, in October 2002. Adult Services Program staff presented the development and implementation of the project and fielded questions from attendees from several other states. Project information was shared and offered to be used as a basis for development of financial institution reporting projects in other states.

Evaluation of Virginia FIR Program Effectiveness

The number of reports of suspected domestic elder abuse (that which occurs in the home, as compared to a long-term care facility) made to state APS programs has increased steadily since 1986, according to the NCEA. In 1986, the number of reports made to APS programs nationally totaled 117,000; in 2000, that figure was 470,709 (a 300 percent increase). In 2000, financial abuse cases made up 11 percent of the total number of substantiated reports investigated by APS (NCEA, 2000 Survey of States, 2002).

Each year, the Adult Services Program conducts a survey of all 120 local departments of social services. Areas addressed include the provision of home-based services and APS reporting. Based on the 2003 Annual Adult Services Survey and data provided by one of the Department's automated data systems, VACIS*, there were 1,205 reports (approximately 10 percent of all adult abuse, neglect, and exploitation reports) of alleged financial exploitation made to the local

departments of social services. Of these, 567 (47 percent) were substantiated. Eighty-six of these reports were made by financial institutions.

Between FY 2002 and FY 2003 (pre- and post-implementation of the Virginia FIR Project), there was close to a 300 percent increase in the number of financial exploitation reports made by all sources. This is a significant increase in the number of financial exploitation reports and is a direct result of the Department's effort to make financial institutions and the public more aware of financial exploitation of adults. The Department will continue to track the number of reports made by financial institutions.

The following table illustrates data on financial institution reporting prior to and after the implementation of the Virginia FIR Project.

COMPARISON OF FINANCIAL INSTITUTION REPORTING 2002-2003

	FY2002	FY2003
Total number of APS reports made	11,306	11,949
# Financial exploitation reports made	302	1,205
% of all APS reports that were for financial exploitation	3%	10%
# Financial exploitation reports substantiated	N/A*	567
# Reports made by financial institutions	N/A*	86
# Local departments conducting financial exploitation training to financial institutions	N/A*	15
# Training sessions held by local departments	N/A*	17
# Persons trained by local departments	N/A*	164
# Training sessions by other entities	N/A	16
# Persons trained by other entities	N/A	734

**VACIS is the only automated source of APS data for the Department. At present, limited data are available through this system. Data that are available cannot be manipulated easily. Information obtained in FY 2003 was provided by responses from local departments of social services through the Annual Adult Services Survey.*

Future Direction

The 1990s brought a significant change in the response of the criminal justice system to adult abuse. Efforts to enhance the role of mandated in adult abuse cases have been meaningful and productive. Training of law-enforcement officials and prosecutors about the problem has

increased. Adult abuse conferences routinely include opportunities for training law-enforcement officials and other mandated reporters.

Legislation treating adult abuse as a crime has been enacted in several states. These laws generally create a crime of "adult abuse" that supplements existing laws governing crimes such as theft, fraud, assault and battery, homicide, rape, etc., which also encompass adult abuse. Some states have enacted laws enhancing penalties for physical and financial crimes against vulnerable adults. Other states have increased existing penalties for adult abuse (Stiegel, L., 2000).

The following are examples of the Virginia's efforts to continue to increase awareness of adult financial exploitation:

- Legislation was passed in the 2004 Session of Virginia General Assembly to add staff of accounting firms to the list of voluntary financial institution reporters (Senate Bill 318/House Bill 952). Significant enhancements to the existing APS statute are included.

- The Department continues to make tool kits available and encourages community partnerships and training efforts between local departments of social services, human services organizations, and financial institutions.

- Department staff at the state, field, and local levels make presentations and provide educational materials upon request. Local departments of social services are encouraged to develop outreach programs to the financial institutions in their communities.

- Adult Services Program staff participate in conferences and workshops geared towards prevention of adult abuse, neglect, and exploitation and provide displays and information. In the past year, these have included the annual conferences of the Virginia Coalition for the Prevention of Elder Abuse, Virginia Guardianship Association, Virginia Elder Rights Coalition, Virginia Coalition for the Aging, the Belle Boone Beard Gerontology Conference at Lynchburg College, and the regional meeting of the Southern Gerontological Society.

- Information on adult financial exploitation is also included annually in the Adult Abuse Awareness packets issued each May. A sample information sheet on adult financial exploitation is included at the end of this report.

Conclusion

Adult financial exploitation should be treated as a crime. The benefits of criminal justice system involvement in these cases are that it may (1) prevent further abuse; (2) result in a perpetrator—often a family member with a mental health or substance abuse problem—getting needed treatment; and (3) result in restitution that a civil judgment would not provide (Stiegel, L., 2000).

It is incumbent upon the Department's Adult Services Program at the state and local levels to continue outreach efforts so that more vulnerable adults can be helped. The Department is

committed to providing education on and preventing financial exploitation of our seniors and adults with disabilities in the Commonwealth.

If you have any questions or comments about the Virginia FIR Project, please call the Department's Adult Services Program at 804-726-7533 or your local department of social services.

Remember, stopping financial exploitation stops a crime. And, it's the right thing to do.

TO REPORT SUSPECTED ADULT ABUSE, NEGLECT, OR FINANCIAL EXPLOITATION,
call your local department of social services or the Virginia Department of Social Services'
24-hour, toll-free Adult Protective Services hotline at:
1-888-832-3858

Indicators of Adult Financial Exploitation

- A confused older person executes a power of attorney.
- Bank activity is erratic, unusual, or uncharacteristic of the older person, such as unusual withdrawals.
- Bank activity is inconsistent with the older person's ability (e.g., the ATM card has been used when the older person is housebound).
- Changes are made in the older person's property titles, will, or other documents, particularly if the person is confused and/or the documents favor new acquaintances.
- Forged or suspicious signature is noted on documents.
- Lack of necessities or amenities is obvious when the older person can afford them.
- Recent, new acquaintances show up, particularly those who take up residence with the older person.
- Suspicious activity is seen on credit card accounts or other financial accounts.
- The older person brings strangers with her to meetings or while she is conducting financial transactions.
- The older person doesn't receive services for which payment has been made.
- The older person exhibits hoarding behavior, such as carrying all her papers in large bags all the time.
- The older person is accompanied by a stranger, family member, or other person who seems to coerce her into making decisions or transactions.
- The older person is being evicted or utilities are being connected.
- The older person is concerned or confused about "missing funds" in her accounts.
- The older person is fearful that she will be evicted or institutionalized, if money is not given to her caregiver.
- The older person gives implausible explanations about what she is doing with her money.
- The older person is missing documents such as those related to pensions, stocks, government payments, etc.
- The older person is not allowed to speak for herself or to make decisions.
- The older person is not aware of, or does not understand, recently completed financial transactions.
- The older person is not cared for or the residence is unkempt when arrangements have been made for providing personal care or home maintenance services.
- The older person seems paranoid (e.g., accuses caregivers of taking or mismanaging her money).
- The older person's mail has been redirected to a different address.

Source: "Financial Abuse of the Elderly: Risk Factors, Screening Techniques, and Remedies," Lori A. Stiegel, Associate Staff Director of the American Bar Association Commission on Legal Problems of the Elderly.